Field Services Division
Reno/Carson City 684-4DMV
Las Vegas 486-4DMV
Rural NV (877) 368-7828
www.dmvnv.com

MINOR APPLICATION TO TRANSPORT MEDICALLY DISABLED

Approved:_____ Denied:_____ Reason: _____

INSTRUCTIONS: Please type or print in **black** ink. Failure to complete **all** sections **AND** to attach a Physician s Statement will cause considerable delay in processing the application.

Name of Minor _____ Date of Birth _____
Social Security Number _____
Male Female Height _____ Weight _____ Hair _____ Eyes _____
Name of Disabled Person _____ Relationship _____
Social Security Number of Disabled Person _____

Both Reside at _____
Mailing Address _____ Home Phone _____

Father/guardian (If other than disabled person)
Name: _____ Drivers License # _____
Employer _____ Address _____
Phone _____Work Days/hours _____

Mother/guardian (If other than disabled person)
Name: _____ Drivers License # _____
Employer _____ Address _____
Phone _____Work Days/hours _____

Is there any other licensed driver(s) residing in the household? Yes_____ No_____
If Yes, please complete the following:

Name _____Drivers License # _____

Name _____Drivers License #_____

Explanation of Medical Hardship and Need for Applicant to Drive
_____
_____

WE / I HEREBY CERTIFY THAT THE MINOR AND DISABLED PERSON ARE NEVADA RESIDENTS AND BOTH RESIDE AT THE SAME ADDRESS. WE / I FURTHER CERTIFY THAT ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND CORRECT AND UNDERSTAND THAT ANY MISSTATEMENT AMY CAUSE DENIAL AND / OR CANCELLATION OF THE LICENSE.

_____ _____
FATHER/GUARDIAN SIGNATURE MOTHER/GUARDIAN SIGNATURE

APPLICATION CONTINUES ON THE REVERSE SIDE

PHYSICIAN S STATEMENT: PLEASE ATTACH A SEPARATE STATEMENT FROM AN ATTENDING PHYSICIAN AS TO THE NATURE OF THE MEDICAL CONDITION AND THE INABILITY OF THE DISABLED PERSON TO OPERATE A MOTOR VEHICLE. THE STATEMENT MUST INDICATE WHETHER THE CONDITION IS PERMANENT OR, IF IT IS A SHORT TERM DISABILITY, THE LENGTH OF TIME ESTIMATED FOR THE DISABILITY. THE STATEMENT MUST BE AN ORIGINAL DOCUMENT ON THE PHYSICIAN'S LETTERHEAD AND DATED WITHIN THE PAST THIRTY (30) DAYS.

DATE/TIME/LOCATION OF SCHEDULED DOCTOR APPOINTMENTS OR THERAPY
(If necessary, please attach an additional sheet.)

Physician or Therapy:_____ Phone: _____

Address of Appointment:_____ City: _____

GROCERY OR DRUG STORE TRAVEL:

Name of grocery store: _____

Address: _____ City: _____

Mileage one way from residence to store via most direct route _____

Route of travel: _____

_____

Name of drug store: _____

Address: _____ City: _____

Mileage one way from residence to store via most direct route _____

Route of travel: _____

_____

You may specify two days each week and a maximum of two hours each day to grocery shop or obtain drug store items:

Days _____ Hours _____

License plate number of vehicle to be used by minor: _____

I / WE ACCEPT ALL LIABILITIES FOR ANY NEGLECT OR WILLFUL MISCONDUCT ON THE PART OF THE MINOR AND AGREE THAT FAILURE OF THE MINOR TO COMPLY WITH THE FOLLOWING RESTRICTIONS AND/OR ANY CONDITIONS OF THE LICENSE MAY RESULT IN CANCELLATION OF THIS PRIVILEGE:

- License will be effective for the specified period of time;
- Licensee may not transport passengers other than the individual named in the application;
- The route, days, and hours of travel shall be confined as determined by the Field Services Division;
- The undersigned will notify the Field Services Division if the need no longer exists.

_____ _____

FATHER/GUARDIAN SIGNATURE DATE MOTHER/GUARDIAN SIGNATURE DATE

SUBSCRIBED and SWORN to or affirmed before me this _____day of_____,19_____.

_____

NOTARY PUBLIC